CHAPTER 4

MEDICARE PAYMENT POLICIES

This chapter discusses Medicare payment policies.

Services That Medicare DOES Pay For

In general, Medicare pays for services that are considered medically reasonable and necessary to the overall diagnosis and treatment of the patient's condition. Services or supplies are considered medically necessary if they:

- Are proper and needed for the diagnosis or treatment of the patient's medical condition;
- Are furnished for the diagnosis, direct care, and treatment of the patient's medical condition;
- Meet the standards of good medical practice; and
- Are not mainly for the convenience of the patient, provider, or supplier.

For every service billed, the provider or supplier must indicate the specific sign, symptom, or patient complaint necessitating the service. Although furnishing a service or test may be considered good medical practice, Medicare generally prohibits payment for services without patient symptoms or complaints.

Medicare pays for provider professional services that are furnished in:

- The U.S. (the Centers for Medicare & Medicaid Services [CMS] recognizes the 50 states, the District of Columbia, Commonwealth of Puerto Rico, Virgin Islands, Guam, Northern Mariana Islands, American Samoa, and territorial waters adjoining the land areas of the U.S. as being within the U.S.); and
- The home, office, institution, or at the scene of an accident.

Covered Part A Inpatient Hospital Services

Subject to certain conditions, limitations, and exceptions the following inpatient hospital or inpatient Critical Access Hospital (CAH) services are furnished to an inpatient of a participating hospital or participating CAH or, in the case of emergency services or services in foreign hospitals, to an inpatient of a qualified hospital:

- Bed and board;
- Nursing and other related services;
- Use of hospital or CAH facilities;
- Medical social services;
- Drugs, biologicals, supplies, appliances, and equipment;
- Certain other diagnostic or therapeutic services;
- Medical or surgical services furnished by certain interns or residents in training; and
- Transportation services including transport by ambulance.

An inpatient is an individual who has been admitted to a hospital for the purpose of receiving inpatient hospital services. Generally, a patient is considered an inpatient if he or she is formally admitted as inpatient with the expectation of remaining at least overnight and occupying a bed. The patient is considered an inpatient even if he or she can later be discharged or transferred to another hospital and does not actually use a hospital bed overnight.

The physician or other practitioner responsible for a patient's care at the hospital is responsible for deciding whether the patient should be admitted as an inpatient. The physician or other practitioner should work closely with hospital staff to ensure a proper admission as an inpatient following hospital admission protocols. The physician or practitioner should also use a 24-hour period as a benchmark by ordering admission for patients who are expected to need hospital care for 24 hours or more and treating other patients on an outpatient basis. The decision to admit a patient is a complex medical judgment that requires the consideration of:

- The patient's medical history and current medical needs, including the severity of the signs and symptoms exhibited;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that will assist in assessing whether the patient should be admitted and that do not ordinarily require him or her to remain at the hospital for 24 hours or more;
- The availability of diagnostic procedures at the time when and where the patient presents;
- The types of facilities available to inpatients and outpatients;
- The hospital's by-laws and admissions policies; and
- The relative appropriateness of treatment in each setting.

In the following situations, coverage of services on an inpatient or outpatient basis is not determined solely on the basis of length of time the patient actually spends in the hospital:

Minor Surgery or Other Treatment

When a patient with a known diagnosis enters a hospital for a specific minor surgical procedure or other treatment that is expected to keep him or her in the hospital for less than 24 hours, for coverage purposes he or she is considered an outpatient regardless of the arrival hour at the hospital, use of a bed, or if he or she remains in the hospital past midnight.

Renal Dialysis Treatments

Renal dialysis treatments are usually covered only as outpatient services for the patient who:

- Resides at home;
- Is ambulatory;
- Has stable conditions; and
- Comes to the hospital for routine chronic dialysis treatments (not for a diagnostic workup or a change in therapy).

The renal dialysis patient with one of the following conditions is usually an inpatient:

- He or she is undergoing short-term dialysis until the kidneys recover from an acute illness (acute dialysis); or
- He or she has borderline renal failure and develops acute renal failure every time he or she has an illness and requires dialysis (episodic dialysis).

A patient may begin dialysis as an inpatient and then progress to outpatient status. If noncovered services that are generally excluded from Medicare coverage are furnished in Non-Prospective Payment Systems hospitals, part of the billed charges or the entire admission may be denied. Appropriately admitted cases in Prospective Payment System (PPS) hospitals include the following:

- If care is noncovered because a patient does not need to be hospitalized, the admission will be denied and the Part A PPS payment will be made only under limitation on liability. Under limitation on liability, Medicare payment may be made when the provider and the patient were unaware that the services were not necessary and could not reasonably be expected to know that they were not necessary. If a patient is appropriately hospitalized but receives only noncovered care (beyond routine services), the admission is denied. An admission that includes covered care, even if noncovered care was also furnished, will not be denied. Under PPS, Medicare assumes that it is paying for only the covered care furnished when covered services needed to treat and/or diagnose the illness are furnished.
- If a noncovered procedure is furnished along with covered nonroutine care, a Diagnosis Related Group change rather than an admission denial might occur. If noncovered procedures elevate costs into the cost outlier category, outlier payment will be denied in whole or in part.

- If a patient receives items or services in excess of, or more expensive than, those for which payment can be made, payment is made only for the covered items or services or the appropriate PPS amount. This provision applies to inpatient services as well as all hospital services under Parts A and B of the Medicare Program. If items or services are requested by the patient, the hospital may charge him or her the difference between the amount customarily charged for the services requested and the amount customarily charged for covered services.

If a patient requires extended care services and is admitted to a bed in a hospital, he or she is considered an inpatient of the hospital. The services furnished in the hospital will not be considered extended care services and payment may not be made unless the services are extended care services furnished pursuant to a swing bed agreement granted to the hospital by the Secretary of Health and Human Services (HHS).

Covered Part B Services

Covered Part B services include, but are not limited to, the following:

- Physician services such as surgery, consultations, office visits, institutional calls;
- Services and supplies furnished incident to physician's professional services;
- Outpatient hospital services furnished incident to physician services;
- Outpatient diagnostic services furnished by a hospital;
- Outpatient physical therapy (PT) services;
- Outpatient occupational therapy (OT) services;
- Outpatient speech-language pathology (SLP) services;
- Diagnostic x-ray tests, laboratory tests, and other diagnostic tests;
- X-ray, radium, and radioactive isotope therapy services;
- Surgical dressings and splints, casts, and other devices used for reduction of fractures and dislocations;
- Rental or purchase of durable medical equipment for use in the patient's home;
- Ambulance services;
- Certain prosthetic devices that replace all or part of an internal body organ;
- Leg, arm, back, and neck braces and artificial legs, arms, and eyes;
- Certain medical supplies used in connection with home dialysis delivery systems; and
- Ambulatory Surgical Center services.

Incident to Provision

To be covered incident to the services of a physician, services and supplies must meet the following four requirements:

1) Commonly furnished in physicians' offices or clinics

Services and supplies commonly furnished in physicians' offices are covered under the incident to provision. Charges for these services and supplies must be included in the physician's bill. To be covered, supplies, including drugs and biologicals, must be an expense to the physician or legal entity billing for the services or supplies.

2) Furnished by the physician or auxiliary personnel under the direct personal supervision of a physician

Services billed as incident to the physician may be furnished by auxiliary personnel or nonphysician practitioners (NPP) under the required level of supervision. Auxiliary personnel are individuals who act under the supervision of a physician regardless of whether the individual is an employee, leased employee, or independent contractor of the physician or of the legal entity that employs or contracts with the physician. A physician may also have the services of certain NPPs covered as incident to his or her professional service. These NPPs include the following:

- Certified nurse midwives (CNM);
- Certified registered nurse anesthetists (CRNA);
- Physical therapists (PT);
- Occupational therapists;
- Clinical psychologists (CP);
- Clinical social workers (CSW);
- Physician assistants (PA);
- Nurse practitioners (NP);
- Clinical nurse specialists (CNS); and
- Audiologists.

The direct supervision for any service, including evaluation and management (E/M) services, can be provided by any member of the group who is physically present on the premises and is not limited to the physician who has established the patient's plan of care.

Direct supervision in the office setting means that the physician is present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service.

Services furnished by auxiliary personnel outside the office setting (e.g., in a patient's home or in an institution other than a hospital or Skilled Nursing Facility [SNF]) are covered incident to a physician's service only if there is personal supervision by the physician. Personal supervision means that a physician is physically in attendance in the same room during the performance of the procedure.

3) Commonly furnished without charge or included in the physician's bill

Incident to services or supplies must represent an expense incurred by the physician or legal entity billing for the services or supplies.

4) An integral, although incidental, part of the physician's professional service

The physician must have furnished a personal professional service to initiate the course of treatment that is being furnished by the NPP as an incidental part. There must also be subsequent service by the physician of a frequency that reflects the physician's continuing active participation in, and management of, the course of treatment. The physician or another physician in the group practice must be physically present in the same office suite and immediately available to render assistance, if necessary.

Although the rehabilitative services of PT, OT, and SLP have their own benefits under the law, it is also acceptable for these services to be billed by physicians incident to their services if the rules for both the therapy benefit and the incident to benefit are met, with one exception. The staff who provide therapy services under the direct supervision of a physician must be qualified as therapists with the exception of any licensure requirements that may apply. For example, PTs must be licensed and graduates of an approved PT curriculum (unless they meet other requirements for foreign or pre-1977 training). Staff who provide PT services must be graduates of an approved PT curriculum, but not necessarily licensed.

The patient record should document the essential requirements for incident to services.

Commonly Furnished Services

Consultations

Consultations are primarily performed at the request of a referring physician or practitioner in order to provide him or her with advice or an opinion. The following guidelines apply to consultations:

- The consultant examines the patient, prepares a written report that details his or her findings, and forwards the report to the referring provider;
- If the intent of the consultation is to see the patient and provide the referring physician or practitioner with advice or an opinion, consultation procedure codes must be included on the claim;
- A consultant may initiate diagnostic treatments and/or therapeutic services;
- If the consultant assumes responsibility for the patient, he or she should use appropriate procedure codes for established or subsequent patient visits based on the place of service;
- All consultation codes billed to Medicare must contain the referring physician's name and Unique Physician/Practitioner Identification Number (UPIN);
- A consultation may also be initiated by the patient and/or a family member in order to obtain a second or third opinion, in which case the physician who performs the consultation should enter his or her name and UPIN on the claim form; and
- Any identifiable procedure or service performed on or subsequent to the date of the initial consultation should be reported separately.

Medical record documentation requirements for consultations include:

- History, examination, and medical decision making components must support the level of care billed;
- The referring provider documents the request and need for advice or an opinion in the patient's medical record;
- The consultant documents his or her advice or an opinion and any services or tests furnished in the patient's medical record; and
- The consultant provides a written report to the referring physician or qualified NPP.

Concurrent care occurs when certain E/M services are furnished by more than one physician with the same or similar specialty on the same date of service. Reasonable and necessary services of each physician who furnish concurrent care may be covered when each is required to play an active role in the patient's course of treatment. Some medical conditions may exist that require diverse specialized medical services. For example, although cardiology is a subspecialty of internal medicine, the treatment of both diabetes and a serious heart condition

may require the concurrent services of two physicians who practice internal medicine but have different subspecialties. Coverage guidelines for concurrent physician services include:

- The patient's medical condition must warrant the services of more than one physician with the same or similar specialty on an attending, rather than consultative, basis;
- The individual services furnished by each physician must be reasonable and necessary;
- The services of two physicians with the same specialty or subspecialty may be required if one physician has limited his or her practice to a unique aspect of that specialty; and
- Medical record documentation must substantiate the need for more than one physician's services.

Diagnostic Tests

Diagnostic tests assist in identifying the nature and underlying cause of illness and may be:

- Personally performed by the physician;
- Performed under the physician's direct supervision by his or her employee; or
- Purchased.

Purchased tests are administered by a supplier's personnel at the physician's office or at another location and are not personally performed by the physician or his or her employee under his or her direct supervision. The definition of a purchased test is not affected by the physician's financial interest in the supplier.

A diagnostic test may be billed in one of the following ways:

- Globally: the same physician performs the test and interprets the results. When billing globally, the physician must either:
    - Personally perform both the professional and the technical components of the test
    - Personally perform the professional component and supervise his or her employee who performs the technical component
- Technical component only: the diagnostic test is performed but not interpreted by the physician. The modifier TC (technical component) is indicated on the claim form to identify these services.
- Professional component only: the physician interprets but does not perform the technical component of the test. The modifier 26 (professional component) is indicated on the claim form to identify these services.

- Purchased technical component: purchased technical component is purchased from an outside supplier and is submitted as a separate item on the claim form. If more than one supplier is used or more than one test is purchased, separate claims must be submitted.
- Purchased professional component: a purchased professional or interpretation component is purchased from an independent physician or medical group. The following guidelines apply to purchased professional component tests:
    - Must be initiated by a physician or medical group that is independent of the physician or medical group furnishing the interpretation
    - The physician or medical group that purchased the interpretation submits the claim form, which must include the following:
        - The name, address, and Medicare Provider Identification Number (PIN) of the physician or medical group that furnishes the interpretation of the test
        - The ordering physician's name and UPIN
        - The acquisition cost or amount paid for the service
    - The interpreting physician or medical group must be enrolled in the Medicare Program
    - The physician or medical group that furnishes the interpretation does not see the patient
    - The purchaser (employee, partner, or owner of the purchaser) of the interpretation performs the technical component of the diagnostic test and
    - The purchaser must keep the interpreting physician's name, address, and PIN on file

<u>Hospice</u>

Hospice care is covered under Part A for the terminally ill beneficiary who meets all of the following conditions:

- The individual is eligible for Part A;
- The individual is certified as having a terminal disease with a prognosis of six months or less if the illness runs its normal course;
- The individual receives care from a Medicare-approved hospice program; and
- The individual signs a statement indicating that he or she elects the hospice benefit and waives all rights to Medicare payments for services for the terminal illness and related conditions. Medicare will continue to pay for covered benefits that are not related to the terminal illness.

Medicare may provide the following hospice services for the terminal illness and related conditions:

- Doctor services;
- Nursing care;
- Medical equipment;
- Medical supplies;
- Drugs for symptom control or pain relief;
- Home health aid and homemaker services;
- PT;
- OT;
- SLP;
- Social worker services;
- Dietary counseling;
- Spiritual counseling;
- Grief and loss counseling for the individual and his or her family; and
- Short-term care in the hospital, including respite care.

Medicare will NOT pay for the following services when hospice care is chosen:

- Treatment intended to cure the terminal illness;
- Care from any provider that was not set up by the elected hospice;
- Care from another provider that is the same care that the individual must receive from his or her hospice;
- Services not covered by Medicare; and
- Services that are not medically reasonable and necessary.

Hospice care is available for 2 periods of 90 days and an unlimited number of 60 day periods. The medical director of the hospice or the physician member of the hospice and interdisciplinary group and the individual's attending physician, if the individual has an attending physician, are required for the initial certification of the terminal illness. To be eligible for the Medicare hospice benefit, a beneficiary requires certification of the terminal condition with a prognosis of six months or less if the disease runs its normal course. Certification is required at the initiation of the benefit period and for each subsequent benefit period. If the individual lives longer than six months, he or she is still eligible for hospice care as long as there is recertification of the terminal illness.

Injections, Drugs, and Biologicals

With the exception of influenza, pneumococcal polysaccharide, and Hepatitis B vaccinations, injections fall within one of the following categories:

- Covered injections for drugs being used for an accepted indication that are not usually self administered and are furnished as the only service to the patient: Bill the procedure code for the administration and bill the procedure code for the drug;
- Covered injections for drugs being used for an accepted indication that are not usually self administered and are furnished during the course of an E/M service: Bill the procedure code for an E/M service and bill the procedure code for the drug; or
- Excluded injections: Medicare does not pay for either the administration of the drug or the drug.

See the Preventive Services Section below for information about influenza, pneumococcal polysaccharide, and Hepatitis B vaccinations.

Outpatient Observation

A patient is considered an outpatient if a physician orders that he or she be placed under observation. The purpose of observation is to determine the need for further treatment or inpatient admission. Observation services are furnished by a hospital on the hospital's premises and include:

- The use of a bed;
- Periodic monitoring by the hospital's nursing or other staff; and
- The services that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient.

Observation services are covered only when they are furnished by the order of a physician or other individual who is authorized by State licensure law and hospital staff by-laws to admit patients to the hospital or order outpatient tests, generally within a 24-hour period and rarely, in exceptional circumstances, within a 48-hour period.

If a hospital intends to place or retain a patient in observation for a noncovered service, it must give the patient proper written advance notice of noncoverage under limitation on liability procedures. The following are not covered as outpatient observation services:

- Services that are not reasonable and necessary for the diagnosis or treatment of the patient and are furnished for the convenience of the patient, the patient's family, or the physician;
- Services that are covered under Part A;
- Services that are part of another Part B service; and
- Standing orders for observation following outpatient surgery.

Preventive Services

The coverage of certain preventive services has been mandated by the Balanced Budget Act of 1997, Benefits Improvement and Protection Act of 2000, and the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. Preventive screenings and services, early detection of disease, and disease management along with professional advice on diet, exercise, weight control, and smoking cessation can help beneficiaries lead healthier lives and prevent, delay, or lessen the impact of disease.

The MMA expanded Part B coverage of preventive services to include an initial preventive physical examination (IPPE), cardiovascular screening blood tests, and diabetes screening tests as described below.

Initial Preventive Physical Examination (also known as the "Welcome to Medicare Physical")

All beneficiaries enrolled in Part B with effective dates that begin on or after January 1, 2005 are eligible for the IPPE benefit. This one-time benefit must be received by the beneficiary within the first six months of Part B coverage. An IPPE consists of all seven of the following components (components must either be furnished or some furnished and some referred):

- Review of the beneficiary's medical and social history, with attention to modifiable risk factors;
- Review of the beneficiary's risk factors for depression;
- Review of the beneficiary's functional ability and level of safety;
- An examination that includes the beneficiary's height, weight, blood pressure measurement, and visual acuity screen;
- Performance and interpretation of an electrocardiogram;
- Education, counseling, and referral based on the results of the review and evaluation services described in the previous five elements; and
- Education, counseling, and referral that includes providing the beneficiary with a brief written plan for obtaining the appropriate screenings and other preventive services that are covered as separate Part B benefits.

The physician, qualified NPP, or hospital may furnish the IPPE and bill Part B separately for it and other preventive services. The IPPE does not include any clinical laboratory tests.

The following should be documented in the beneficiary's medical record:

- That each component of the IPPE was either furnished or some were furnished and some were referred;
- The separate, medically necessary E/M services that were furnished; and
- All referrals and a written medical plan.

The beneficiary is responsible for paying the coinsurance or copayment associated with receiving an IPPE after he or she has met the yearly Part B deductible. The deductible does not apply to beneficiaries who receive an IPPE in a Federally Qualified Health Center (FQHC).

Cardiovascular Screening Blood Tests

For services furnished on or after January 1, 2005, the following cardiovascular screening blood tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of heart disease and stroke are covered for all asymptomatic beneficiaries once every five years (at least 59 months after the last covered screening tests):

- Total cholesterol;
- High-density lipoproteins; and
- Triglycerides.

The following information must be included in the beneficiary's medical record:

- The screening test was ordered by a physician or qualified NPP;
- The beneficiary is asymptomatic;
- The purpose of the screening test is for early detection of cardiovascular disease;
- The test was performed after a 12-hour fast; and
- Appropriate supporting procedure and diagnosis codes.

The beneficiary pays no deductible, coinsurance, or copayment for these cardiovascular screening blood tests.

Diabetes Screening Tests

For services furnished on or after January 1, 2005, Medicare covers diabetes screening tests with a referral from a physician or qualified NPP as follows:

- Beneficiaries who are non-diabetic and not previously diagnosed as pre-diabetic may receive one diabetes screening test within a 12-month period (at least 11 months have passed following the month in which the last covered diabetes screening test was performed).
- Beneficiaries who have any of the following may receive a maximum of two diabetes screening tests within a 12-month period (but not less than 6 months apart):
    1) Diagnosed with pre-diabetes
    2) Have any of the following risk factors:
        - Hypertension
        - Dyslipidemia (history of abnormal cholesterol and triglyceride levels)
        - Obesity (a body mass index greater than or equal to 30kg/m^2) or
        - Previous identification of an elevated impaired fasting glucose or impaired glucose tolerance
    3) Have a risk factor for diabetes consisting of at least two of the following characteristics:
        - Overweight (a body mass index greater than 25 but less than 30kg/m^2)
        - A family history of diabetes (parents, brothers, or sisters)
        - Age 65 or older
        - A history of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds

Covered diabetes blood screening tests include:

- Fasting blood glucose; and
- Post-glucose challenge, not limited to:
    - Oral glucose tolerance with a glucose challenge of 75 grams of glucose for non-pregnant adults or
    - 2-hour post-glucose challenge test alone

The beneficiary pays no deductible, coinsurance, or copayment for these diabetes screening tests.

Other preventive services covered under Part B are discussed below.

Diabetes Self-Management Training Services

Diabetes self-management training (DSMT) services are covered for beneficiaries who:

- Have recently been diagnosed with diabetes;
- Have been determined to be at risk for complications from diabetes; or
- Were diagnosed with diabetes before meeting Medicare eligibility requirements and have since become eligible for coverage.

A qualified DSMT program includes:

- Instruction on self-monitoring of blood glucose;
- Education about diet and exercise;
- An insulin treatment plan developed specifically for insulin dependent patients; and
- Motivation for patients to use the skills for self-management.

Individuals who have been impacted by any of the following situations may benefit from receiving DSMT services:

- Problems controlling blood sugar;
- Beginning diabetes medication or switching from oral diabetes medication to insulin;
- Diagnosed with eye disease related to diabetes;
- Lack of feeling in feet or other foot problems such as ulcers or deformities or an amputation was performed;
- Treated in an emergency room or has stayed overnight in a hospital because of diabetes; or
- Diagnosed with kidney disease related to diabetes.

DSMT services are covered by Medicare only if the physician or qualified NPP who is managing the beneficiary's diabetic condition certifies that the services are needed under a comprehensive plan of care. The plan of care must be written and signed by the physician or qualified NPP, be reasonable and necessary, and include the following information:

- Number of sessions (up to 10 hours), frequency, and duration of the training;
- Topics to be covered in training (initial training hours can be used to pay for the full program curriculum or specific areas such as nutrition or insulin training);
- A determination regarding whether the beneficiary should receive individual or group training; and
- Any changes to the plan of care, if applicable.

Additional DSMT services coverage requirements include that the DSMT program must:

- Be accredited by the American Diabetes Association (ADA) or Indian Health Service (IHS);
- Provide services to eligible Medicare beneficiaries that are diagnosed with diabetes; and
- Submit an accreditation certificate from the ADA, IHS, or another CMS-recognized program to the local Medicare Contractor's provider enrollment department.

The provider of DSMT services must maintain documentation in the beneficiary's medical record that includes the original order from the physician and any special conditions noted by the physician.

The beneficiary is responsible for paying the coinsurance or copayment for DSMT services after he or she has met the yearly Part B deductible.

Medical Nutrition Therapy

The following medical nutrition therapy (MNT) services are covered for beneficiaries who have been diagnosed with diabetes or a renal disease and the physician has prescribed and provided a referral for the services:

- An initial nutrition and lifestyle assessment;
- Nutrition counseling;
- Information about managing lifestyle factors that affect diet; and
- Follow-up sessions to monitor progress.

Duration and frequency limit guidelines that apply to MNT services include:

- Three hours of one-on-one counseling services for the first year;
- Two hours of coverage for subsequent years;
- The dietician or nutritionist may choose how many units are provided per day;
- Additional hours may be covered if the physician orders additional hours of MNT based on a change in medical condition, diagnosis, or treatment regimen; and
- The physician must prescribe the services and renew the referral for services on a yearly basis.

MNT services must be furnished by one of the following providers:

- Qualified dietitian;
- Licensed registered dietitian;
- Licensed nutritionist who meets the registered dietitian requirement; or
- Grandfathered nutritionist who was licensed as of December 12, 2000.

The beneficiary is responsible for paying the coinsurance or copayment for MNT services after he or she has met the yearly Part B deductible.

Screening Pap Test

Medicare provides coverage of a screening Pap test for all female beneficiaries when the test is ordered and collected by a doctor of medicine, doctor of osteopathy, CNM, PA, NP, or CNS who is authorized under State law to perform the examination based on one of the following guidelines:

- Once every 12 months (at least 11 months have passed following the month that the last covered Pap test was performed) when there is evidence:
    - That the woman (on the basis of her medical history or other findings) is of childbearing age and has had an examination that indicates the presence of cervical or vaginal cancer or other abnormalities during any of the preceding 3 years
    - That the woman is in one of the high risk categories for developing cervical or vaginal cancer or other specified personal history presenting hazards to health
- Once every 24 months (at least 23 months have passed following the month in which the last covered screening Pap test was performed):
    - For all other female beneficiaries who are at low risk for developing cervical or vaginal cancer

The high risk factors for cervical cancer include:

- Early onset of sexual activity (under 16 years of age);
- Multiple sexual partners (5 or more in a lifetime);
- History of a sexually transmitted disease, including Human Papillomavirus (HPV) and/or Human Immunodeficiency Virus (HIV) infection; and
- Fewer than 3 negative Pap tests within the previous 7 years.

The high risk factors for vaginal cancer include:

- Diethylstilbestrol (DES)-exposed daughters of women who took DES during pregnancy.

The beneficiary is responsible for paying the coinsurance or copayment for the Pap test collection. There is no Part B deductible for the Pap test collection. The beneficiary pays no deductible, coinsurance, or copayment for the Pap laboratory test.

Screening Pelvic Examination

Medicare provides coverage of screening pelvic examinations for all female beneficiaries when they are furnished by a doctor of medicine, doctor of osteopathy, CNM, PA, NP, or CNS who is authorized under State law to perform the examination. Pelvic screening examinations do not have to be ordered by a physician or other authorized practitioner and are covered based on one of the following guidelines:

- Once every 12 months (at least 11 months have passed following the month in which the last covered pelvic examination was performed) when one or both of the following criteria are met:
    - There is evidence that the beneficiary is in one of the high risk categories for developing cervical or vaginal cancer or other specified personal history that presents a hazard to health and/or
    - A beneficiary of childbearing age has had an examination that indicated the presence of cervical or vaginal cancer or other abnormality during the preceding 3 years
- Once every 24 months (at least 23 months have passed following the month in which the last covered pelvic examination was performed) for:
    - All other female beneficiaries

The high risk factors for cervical cancer include:

- Early onset of sexual activity (under 16 years of age);
- Multiple sexual partners (5 or more in a lifetime);
- A history of a sexually transmitted disease, including HPV and/or HIV infection; and
- Fewer than 3 negative Pap tests within the previous 7 years.

The high risk factors for vaginal cancer include:

- DES-exposed daughters of women who took DES during pregnancy.

A screening pelvic examination should include at least seven of the following elements:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge;
- Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses; and

- Pelvic examination (with or without specimen collection for smears and cultures) including:
    - External genitalia (general appearance, hair distribution, or lesions)
    - Urethral meatus (size, location, lesions, or prolapse)
    - Urethra (masses, tenderness, or scarring)
    - Bladder (fullness, masses, or tenderness)
    - Vagina (general appearance, estrogen effect, discharge lesions, pelvic support, cystocele, or rectocele)
    - Cervix (general appearance, discharge, or lesions)
    - Uterus (size, contour, position, mobility, tenderness, consistency, descent, or support)
    - Adnexa/parametria (masses, tenderness, organomegaly, or nodularity)
    - Anus and perineum

The beneficiary is responsible for paying the coinsurance or copayment for the pelvic screening examination. There is no Part B deductible for the screening pelvic examination.

Screening Mammography Services

Medicare provides coverage for mammography screening, which is a radiologic procedure on an asymptomatic female for the early detection of breast cancer that serves as a baseline to which future screening or diagnostic mammograms may be compared, as follows:

- Annually (at least 11 full months have passed following the month in which the last covered screening mammography was performed) for all female beneficiaries age 40 or older; and
- One baseline mammogram for female beneficiaries between the ages of 35 and 39.

The following guidelines apply to screening mammography services:

- A physician's prescription or referral is not required for a screening mammography;
- Services must be provided at Food and Drug Administration (FDA) certified radiological facility; and
- The results must be interpreted by a qualified physician who is directly associated with the facility at which the mammogram was taken.

A female beneficiary may be at high risk for developing breast cancer if she:

- Has a personal history of breast cancer;
- Has a family history of breast cancer;
- Had her first baby after age 30; or
- Has never had a baby.

The beneficiary is responsible for paying the coinsurance or copayment for a screening mammography. There is no Part B deductible for a screening mammography.

Colorectal Cancer Screening

Medicare provides coverage for colorectal cancer screenings as follows:

- Fecal occult blood test (stool test), with written order from the beneficiary's attending physician
    - Once every 12 months (at least 11 months have passed following the month in which the last covered screening fecal occult blood test was performed) for all beneficiaries age 50 and older
    - An immunoassay-based fecal occult blood test may be performed as an alternative to the guaiac-based fecal occult blood test
- Flexible sigmoidoscopy, when ordered by a doctor of medicine or a doctor of osteopathy
    - For beneficiaries at high risk for developing colorectal cancer
        - Once every 4 years (at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was performed) for all beneficiaries age 50 and older
    - For beneficiaries not at high risk for developing colorectal cancer
        - Once every 4 years (at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was performed) for all beneficiaries age 50 and older
        - If the beneficiary has had a screening colonoscopy within the preceeding 10 years, the next screening flexible sigmoidoscopy will be covered only after at least 119 months have passed following the month in which the last covered colonoscopy was performed
- Screening colonoscopy, when performed by a doctor of medicine or a doctor of osteopathy
    - For beneficiaries at high risk for developing colorectal cancer
        - Once every 2 years for beneficiaries of any age
    - For beneficiaries not at high risk for developing colorectal cancer
        - Once every 10 years, but not within 47 months of a previous screening sigmoidoscopy

- Barium enema, as an alternative to a screening flexible sigmoidoscopy or screening colonoscopy
    - For beneficiaries of any age at high risk for developing colorectal cancer
        - Every 2 years (at least 23 months have passed following the month in which the last covered screening barium enema was performed)
    - For beneficiaries age 50 and older who are not at high risk for developing colorectal cancer
        - Once every 4 years (at least 47 months have passed following the month in which the last covered screening barium enema was performed)

The following guidelines apply to screening barium enemas:

- Must be ordered in writing after a determination that the procedure is appropriate;
- If the beneficiary cannot withstand a double contrast barium enema, the attending physician may order a single contrast barium enema.
- The attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the estimated screening potential for a screening flexible sigmoidoscopy or screening colonoscopy, as appropriate, for the same individual.

The high risk factors associated with colorectal cancer include any of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;
- A family history of familial adenomatous polyposis;
- A family history of hereditary nonpolyposis colorectal cancer;
- A personal history of adenomatous polyps;
- A personal history of colorectal cancer; or
- A personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

The beneficiary pays no deductible, coinsurance, or copayment for fecal occult blood tests. The beneficiary is responsible for paying the coinsurance or copayment for flexible sigmoidoscopies, colonoscopies, and barium enemas after he or she has met the yearly Part B deductible. The beneficiary is responsible for 25 percent of the Medicare-approved amount after he or she has met the yearly Medicare Part B deductible for flexible sigmoidoscopies and colonoscopies that are performed in hospital outpatient departments.

Prostate Cancer Screening

The following guidelines apply to Medicare coverage of tests that detect prostate cancer:

- Prostate Specific Antigen (PSA) Blood Test
    - Once every 12 months (at least 11 months have passed following the month in which the last covered PSA test was performed) for male beneficiaries age 50 or older (coverage begins at least one day after attaining age 50) and
    - Must be ordered by a doctor of medicine, a doctor of osteopathy, CNM, PA, NP, or CNS who is
        - Authorized under State law to perform the examination
        - Fully knowledgeable about the beneficiary's medical condition
        - Responsible for using the results of any examination performed in the overall management of the beneficiary's medical problem

- Digital Rectal Examination (DRE)
    - Once every 12 months (at least 11 months have passed following the month in which the last covered DRE was performed) for male beneficiaries age 50 or older (coverage begins at least one day after attaining age 50) and
    - Must be performed by a doctor of medicine, a doctor of osteopathy, CNM, PA, NP, or CNS who is
        - Authorized under State law to perform the examination
        - Fully knowledgeable about the beneficiary's medical condition
        - Responsible for using the results of any examination performed in the overall management of the beneficiary's medical problem

High risk factors associated with prostate cancer include the following:

- A close relative (father, brother, or son) has a history of prostate cancer.

The beneficiary pays no deductible, coinsurance, or copayment for PSA blood tests. The beneficiary is responsible for paying the coinsurance or copayment after the yearly Part B deductible has been met for DREs.

Bone Mass Measurements

Effective for services furnished on or after July 1, 1998, bone mass measurements or bone density studies, including the physician's interpretation of the results of the procedure, are covered under Medicare every 2 years (at least 23 months have passed following the month in which the last covered bone density study was performed) when performed on a qualified individual at clinical

risk for osteoporosis. If medically necessary, Medicare may provide coverage for a beneficiary more frequently than every 2 years. A qualified individual meets at least one of the following medical indications:

- A woman who has been determined by the treating physician or qualified NPP to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings;
- An individual with vertebral abnormalities, as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia (low bone mass), or vertebral fracture;
- An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to 7.5 mg of prednisone or greater per day for more than 3 months;
- An individual with known primary hyperparathyroidism; or
- An individual being monitored to assess the response to or efficacy of a FDA approved osteoporosis drug therapy.

In addition, all of the following coverage criteria must be met:

- Following an evaluation of the need for a bone mass measurement, the physician or qualified NPP treating the beneficiary must provide an order that includes a determination as to the medically appropriate measurement to be used for the individual;
- The service must be furnished by a qualified provider or supplier of such services under the appropriate level of supervision by a physician;
- The service must be reasonable and necessary for diagnosing, treating, or monitoring an individual as defined above; and
- The service must be a radiologic or radioisotopic procedure (or other procedure) that meets the following requirements:
    - Performed with a bone densitometer (other than dual photon absorptiometry or bone sonometer device [ultrasound]) approved or cleared for marketing by the FDA for bone density study purposes
    - Performed for the purpose of identifying bone mass, detecting bone loss, or determining bone quality and
    - Includes a physician's interpretation of the results of the procedure

The factors that place an individual at increased risk for developing osteoporosis include the following:

- Age 50 or older;
- Female gender;
- A family history of broken bones;
- A personal history of broken bones;
- Caucasian or Asian ethnicity;
- Small bone structure;
- Low body weight (less than 127 pounds);
- Frequent smoking or drinking; or
- Low-calcium diet.

Medical record documentation maintained by the treating physician must clearly indicate the medical necessity for ordering bone mass measurements. Documentation may be included in any of the following:

- Patient history and physical;
- Office notes;
- Test results with written interpretation; or
- X-ray/radiology with written interpretation.

The beneficiary is responsible for paying the coinsurance or copayment for bone mass measurements after he or she has met the yearly Part B deductible.

Glaucoma Screening

Glaucoma screenings are covered by Medicare annually (at least 11 months have passed following the month in which the last covered glaucoma screening examination was performed) when:

- The services are furnished by or under the direct supervision of an optometrist or ophthalmologist
- The optometrist or ophthalmologist is legally authorized to perform the services under State law; and
- The services are furnished in the office setting for eligible beneficiaries in one of the following high risk groups:
    - Individuals with diabetes mellitus
    - Individuals with a family history of glaucoma
    - African Americans age 50 or over or
    - Hispanic Americans age 65 or over (beginning on or after January 6, 2006)

A glaucoma screening includes:

- A dilated eye examination with an intraocular pressure measurement; and
- A direct ophthalmoscopy or slit-lamp biomicroscopic examination.

The beneficiary is responsible for paying the coinsurance or copayment for glaucoma screenings after he or she has met the yearly Part B deductible.

Influenza Vaccinations

Medicare provides coverage for one influenza vaccine and its administration per influenza season for all Medicare beneficiaries regardless of risk for the disease. Vaccination is recommended for individuals that fall within one or more of the following high risk or priority groups:

- Individuals age 65 or older;
- Children less than 3 years old;
- All women who will be pregnant during the flu season;
- Individuals of any age who have Acquired Immunodeficiency Syndrome (AIDS) and certain underlying health conditions such as heart or lung disease and transplant recipients;
- Residents of nursing homes and long-term care facilities;
- Children 2 - 18 years old on chronic aspirin therapy;
- Health care workers involved in direct patient care; and
- Out-of-home caregivers and household contacts of children less than 6 months of age or individuals in the high risk groups.

The beneficiary pays no deductible, coinsurance, or copayment for the influenza vaccine. If the beneficiary receives the influenza vaccination from a provider who does not accept assignment, the beneficiary pays the usual charge for administration of the vaccine.

Pneumococcal Polysaccharide Vaccinations

Medicare provides coverage for the pneumococcal polysaccharide vaccine (PPV) and its administration once in a lifetime for all Medicare beneficiaries. The following high priority target groups have been identified by the Centers for Disease Control:

- Individuals age 65 or older
- Individuals with a serious long-term health problem such as heart disease, sickle cell disease, alcoholism, leaks of cerebrospinal fluid, lung disease (not including asthma), diabetes, or liver cirrhosis

- Individuals with a lowered resistance to infection due to:
    - Hodgkin's disease
    - Multiple myeloma
    - Cancer treatment with x-rays or drugs
    - Treatment with long-term steroids
    - Bone marrow or organ transplant
    - Kidney failure
    - HIV/AIDS
    - Lymphoma, leukemia, or other cancers
    - Nephritic syndrome or
    - Damaged spleen or no spleen
- Alaskan Natives or individuals from certain Native American populations

Beneficiaries who are not sure of their vaccination status or are at high risk may be revaccinated if at least five years have passed since the last covered PPV. Revaccination is limited to the following beneficiaries with:

- Functional or anatomic asplenia (e.g., sickle cell disease or splenectomy);
- HIV infection;
- Leukemia;
- Lymphoma;
- Hodgkin's disease;
- Multiple myeloma;
- Generalized malignancy;
- Chronic renal failure;
- Nephrotic syndrome; or
- Other conditions associated with immunosuppression such as organ or bone marrow transplantation and immunosuppressive chemotherapy.

The beneficiary pays no deductible, coinsurance, or copayment for the vaccine. If the beneficiary receives the vaccination from a provider who does not accept assignment, the beneficiary pays the usual charge for administration of the vaccine.

Hepatitis B Vaccinations

Medicare provides coverage for Hepatitis B vaccinations for the following beneficiaries who are at high or intermediate risk for Hepatitis B Virus (HBV) infection when ordered by a doctor of medicine or a doctor of osteopathy:

- Individuals with End-Stage Renal Disease (ESRD);
- Individuals with hemophilia who received Factor VIII or IX concentrates;
- Clients of institutions for the mentally handicapped;
- Persons who live in the same household as a HBV carrier;
- Homosexual men;
- Illicit injectable drug users;
- Staff in institutions for the mentally handicapped;
- Health care professionals who have frequent contact with blood or blood-derived body fluids during routine work.

Individuals in the above risk group who have laboratory evidence positive for antibodies to HBV are not considered at high or intermediate risk of contracting HBV infection.

The beneficiary is responsible for paying the coinsurance or copayment for Hepatitis B vaccinations after he or she has met the yearly Part B deductible.

Smoking and Tobacco Use Cessation Counseling

For services furnished on or after March 22, 2005, Medicare Part B covers two new levels of counseling, intermediate and intensive, for smoking and tobacco use cessation counseling. This coverage is beyond the minimal smoking and tobacco use cessation counseling that is already considered to be covered at each E/M visit. Coverage is limited to beneficiaries who:

- Are competent and alert at the time services are furnished; and
- Use tobacco AND
    - Have a disease or adverse health effect found by the U.S. Surgeon General to be linked to tobacco use or
    - Are taking certain therapeutic agents whose metabolism or dosage is affected by tobacco use based on FDA-approved information

Two cessation attempts are covered each year. Each attempt may include a maximum of 4 intermediate or intensive sessions, up to 8 sessions in a 12-month period. The practitioner and patient have the flexibility to choose between intermediate or intensive cessation strategies for each attempt. These services are covered for outpatient and hospitalized beneficiaries who are smokers and qualify based on the above guidelines when furnished by qualified physicians or other Medicare-recognized practitioners (including providers).

The beneficiary is responsible for paying the coinsurance or copayment for smoking and tobacco use cessation counseling services after he or she has met the yearly Part B deductible.

To access the *Quick Reference Information: Medicare Preventive Services* job aid, visit *www.cms.hhs.gov/MLNProducts/downloads/qr_prevent_serv.pdf* on the CMS website.

Telehealth Services

Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site. Originating sites (location of the beneficiary) include the following:

- Physician or practitioner offices;
- Hospitals;
- CAHs;
- Rural Health Clinics; and
- FQHCs.

The originating site must be located in a rural HPSA or non-Metropolitan Statistical Area county. Entities that participate in a Federal Telemedicine demonstration project approved by (or receiving funding from) the Secretary of HHS as of December 31, 2000 qualify regardless of geographic location.

Practitioners at the distant site who may furnish and receive payment for telehealth services are:

- Physicians;
- NPs;
- PAs;
- CNMs;
- CNSs;
- CPs; and
- CSWs.

The current list of Medicare telehealth services include:

- Consultations (Current Procedural Terminology [CPT] codes 99241 – 99275®);
- Office or other outpatient visits (CPT codes 99201 – 99215);
- Individual psychotherapy (CPT codes 90804 – 90809);
- Pharmacologic management (CPT code 90862);
- Psychiatric diagnostic interview examination (CPT code 90801) (effective March 1, 2003); and
- ESRD-related services included in the monthly capitation payment (Healthcare Common Procedure Coding System [HCPCS] codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318) (effective January 1, 2005).

Note: With regard to ESRD-related services, at least one face-to-face, "hands on" visit (not telehealth) must be furnished each month to examine the vascular access site by a physician, PA, NP, or CNS.

As a condition of payment, an interactive audio and video telecommunications system must be used that permits real-time communication between the physician or practitioner at the distant site and the beneficiary at the originating site. Asynchronous "store and forward" technology is permitted only in Federal telehealth demonstration programs conducted in Alaska or Hawaii.

Payment is made for the telehealth service furnished by the physician or practitioner at the distant site and a telehealth facility fee is made to the originating site. Claims for telehealth services should be submitted using the appropriate CPT or HCPCS code for the professional service and the telehealth modifier "GT" "via interactive audio and video telecommunications system" (e.g., 99243 GT). In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, submit the appropriate CPT code and telehealth modifier "GQ" "via asynchronous telecommunications system" (e.g., 99243 GQ). Claims for the facility fee should be submitted using HCPCS code Q3014: "Telehealth originating site facility fee."

To find additional information about telehealth services, visit *www.cms.hhs.gov/Telehealth* on the CMS website.

Services That Medicare Does NOT Pay For

The services that Medicare does not pay for include the following:

- Excluded services:
  - Acupuncture
  - Care furnished in facilities located outside the U.S., except in limited cases
  - Cosmetic surgery, unless medically necessary to perform the procedure (e.g., a car accident disfigures facial structure and reconstruction is needed)
  - Custodial care (e.g., assistance with bathing and dressing) at the patient's home or in a nursing home
  - Most dental services
  - Hearing examinations
  - Orthopedic shoes
  - Routine eye care
  - Routine foot care, with the exception of certain patients with diabetes
  - Routine or annual physical examinations (with the exception of IPPEs)
  - Screening tests with no symptoms or documented conditions, with the exception of certain preventive screening tests (see the Preventive Services Section above for information about preventive screening tests)
  - Services related to excluded services and
  - Vaccinations, with certain exceptions (see the Injections, Drugs, and Biologicals and the Preventive Services Sections above for information about vaccinations)

- Services that are considered not medically necessary:
  - Services furnished in a hospital or SNF that, based on the patient's condition, could have been furnished elsewhere (e.g., the patient's home or a nursing home)
  - Hospital or SNF services that exceed Medicare length of stay limitations
  - E/M services that are in excess of those considered medically reasonable and necessary
  - Therapy or diagnostic procedures that are in excess of Medicare usage limits and
  - Services not warranted based on the diagnosis of the patient

- Services that have been denied as bundled or included in the basic allowance of another service:
    - Fragmented services included in the basic allowance of the initial service
    - Prolonged care (indirect)
    - Physician standby services
    - Case management services (e.g., telephone calls to and from the patient) and
    - Supplies included in the basic allowance of a procedure

- Claims that have been denied as "unprocessable"

To find additional information about payment policies, see the Medicare Benefit Policy Manual (Pub. 100-2) at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.